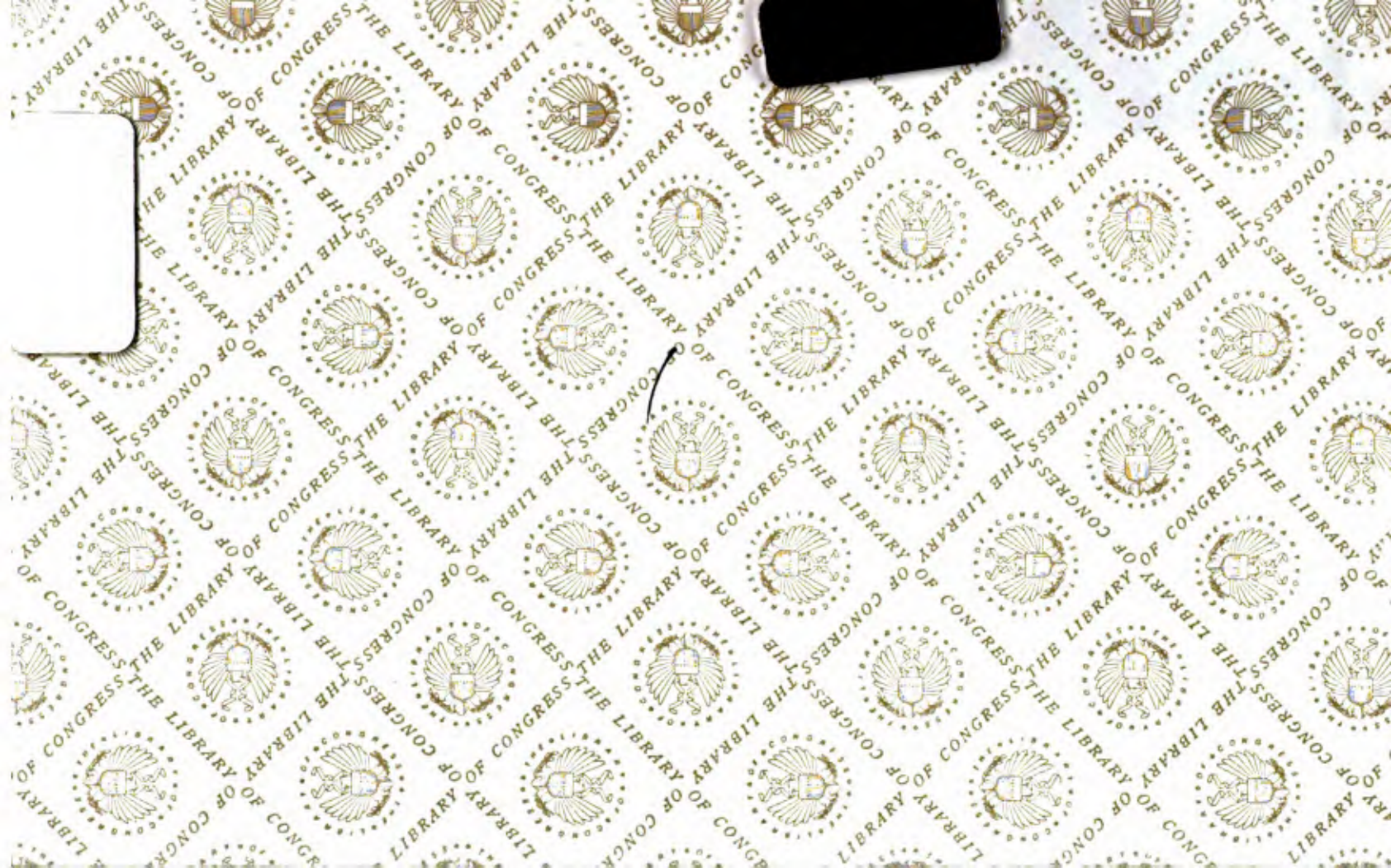
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HEALTH SERVICES FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

HEARING

BEFORE THE

SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE

OF THE

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES

NINETY-FIRST CONGRESS

FIRST SESSION

ON

H.R. 13432

A BILL TO AMEND THE PUBLIC HEALTH SERVICE ACT TO EXTEND THE PROGRAM OF ASSISTANCE FOR HEALTH SERVICES FOR MIGRANT AGRICULTURAL WORKERS, TO PROVIDE ASSISTANCE FOR HEALTH SERVICES FOR OTHER SEASONAL AGRICULTURAL WORKERS, AND FOR OTHER PURPOSES

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HEALTH SERVICES FOR MIGRATORY AND SEASONAL AGRICULTURAL WORKERS

MONDAY, SEPTEMBER 29, 1969

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON PUBLIC HEALTH AND WELFARE,
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 2123, Rayburn House Office Building, Hon. John Jarman (chairman of the subcommittee) presiding.

Mr. JARMAN. The subcommittee will please be in order.

The hearing today is on H.R. 13432, a bill to extend for 3 years the existing program of grants for health services for agricultural workers.

(The text of H.R. 13432 and departmental reports thereon follow:)

[H.R. 13432, 91st Cong., 1st Sess., introduced by Mr. Rogers of Florida on August 11, 1969]

A BILL To amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That (a) section 310 of the Public Health Service Act (42 U.S.C. 242h) is ameuded (1) by striking out "and" after "uext fiscal year," and (2) by inserting after "June 30, 1970," the following: "$30,000,000 for the fiscal year ending June 30, 1971, $45,000,000 for the fiscal year ending June 30, 1972, and $60,000,000 for the fiscal year ending June 30, 1973,".

(b) Such section is further amended (1) by striking out "domestic agricultural migratory workers" each place it appears and inserting in lieu thereof in each such place "migrant and other seasonal agricultural workers", and (2) by striking out "such migratory workers" and inserting in lieu thereof "such workers".

(c) Such section is further amended by striking out "to improve health services for and the health conditions of" in clause (1) (it) and inserting in lieu thereof "to improve and provide a continuity in health services for and to improve the health conditions of".

(d) Such section is further amended by inserting "(including allied health professions personnel)" after "training persons" each place it appears in clause (1).

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D.C., October 14, 1969.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your request of August 12, 1969, for our views on H.R. 13432, a bill "To amend the Public Health Service Act to extend the program of assistauce for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes."

Dr. Roger O. Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Walfare, presented a written statement

before your Committee on September 29, 1969. For the reasons set forth in that statement, we recommend a two-year extension of Section 310 of the PHS Act (42 USC 242h) to provide health services for migrant agricultural workers. Further, we recommend deletion of specific annual authorizations and the provision of an indefinite authorization to provide greater flexibility in determining the annual program level.

Sincerely yours,

WILFRED H. ROMMEL,
Assistant Director for Legislative Reference.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
October 17, 1969.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in response to your request of August 12, 1969, for a report on H.R. 13432, a bill "To amend the Public Health Service Act to extend the program of assistance for health services for migrant agricultural workers, to provide assistance for health services for other seasonal agricultural workers, and for other purposes."

The bill would extend for three additional years the authorization in section 310 of the Public Health Service Act for project grants to provide health services for migrant farm workers and their families. The present authorization expires June 30, 1970. For the three additional years the bill would authorize appropriations of $30 million for Fiscal Year 1971, $45 million for 1972, and $60 million for 1973. In addition, the bill includes an amendment to broaden the definition of program beneficiaries to include "other seasonal agricultural workers" and clarifying amendments relating to the purpose of the grants authorized and to the language authorizing the use of grant funds for the training of allied health personnel.

The views of our Department on this proposed legislation were outlined in testimony presented to your Subcommittee on Public Health and Welfare by Assistant Secretary Egeberg on September 29, 1969. In brief, we recommend that, in lieu of enactment of the provisions of H.R. 13432, the present provisions of section 310 of the Public Health Service Act be extended for two additional fiscal years, with an indefinite appropriations authorization—i.e., "such sums as may be necessary."

We are advised by the Bureau of the Budget that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely,

ROBERT H. FINCH, *Secretary.*

Mr. JARMAN. Approximately 1 million Americans and their families move from place to place throughout the United States during the crop season in response to needs for agricultural labor. Because of low income, lack of education, and lack of eligibility for health care, the health needs of this group of Americans are among the most acute in the Nation.

This is reflected in mortality rates for this group of American citizens, which are substantially above mortality rates for the Nation as a whole.

The most recent congressional consideration of this program occurred last year, at which time the program was extended through June 30, 1970. At the time the program was extended, the statement of the managers on the part of the House stated that the consensus of the conferees was that this program should be considered as a permanent and as a separately identifiable program within the Department.

We feel that this program is an essential one as a supplement to State programs because the transient nature of the residence of agricultural workers at the places of their employment is frequently less

than is required in order for these people to qualify for health services under State and local programs.

The bill under consideration today would extend the existing program of project grants for health services and provide coverage for additional groups of agricultural workers if their employment is seasonal in nature.

The bill also would provide for more continuity of health services and would provide additional authority for training of personnel.

Our first witness this morning will be Dr. Roger Egeberg, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare. Dr. Egeberg, we are glad to have you with us today.

Would you please introduce your associates who accompany you?

STATEMENT OF HON. ROGER O. EGEBERG, M.D., ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; ACCOMPANIED BY JAMES H. CAVANAUGH, DEPUTY ASSISTANT SECRETARY FOR HEALTH AND SCIENTIFIC AFFAIRS, DR. JOHN W. CASHMAN, DIRECTOR, COMMUNITY HEALTH SERVICE, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, AND HELEN L. JOHNSTON, COORDINATOR FOR MIGRANT AND RURAL HEALTH

Dr. EGEBERG. Yes. First, let me say it is a pleasure for me to be able to come and speak on a subject about which I feel so strongly. I was in California over the last 4 days on Government business, and heard about this hearing Friday or Saturday. It was evidence of your interest that moved up my return.

I came back and I have had background briefings, and I am happy to be here.

On my left is Miss Helen L. Johnston, who is Coordinator for Migrant and Rural Health, Community Health Service.

On my immediate right is James H. Cavanaugh, who is one of the Deputy Assistant Secretaries, and beyond him is Dr. John Cashman, Director of The Community Health Service.

Mr. Chairman and members of the committee, I would like to present my statement and then be open to any questions. Is that all right?

Mr. JARMAN. Certainly.

Dr. EGEBERG. I am happy to appear before you today concerning legislation to extend the expiring authorization for project grants to improve health services for migrant agricultural workers and their families.

The bill under consideration today—H.R. 13432, introduced by Mr. Rogers—would extend for 3 additional years the grant authorizations in section 310 of the Public Health Service Act. For these 3 additional years, the bill would authorize appropriations of $30 million for fiscal year 1971, $45 million for 1972, and $60 million for 1973. In addition, it includes an amendment to broaden the definition of program beneficiaries to include other seasonal agricultural workers and clarifying amendments relating to the purpose of the grants authorized and to the language authorizing the use of grant funds for the training of allied health personnel.

Migrant farmworkers and families present a unique problem in the planning and delivery of health care. They are unequally distributed over the Nation's States and counties. They reside in particular places for only brief periods each year. In each place they are strangers. Many—although they have been American citizens for a generation or two—still speak Spanish more easily than English. Some speak no English at all.

Wide dispersion in isolated areas, lack of familiarity with their temporary communities, fear of community hostility, unfamiliarity with modern health concepts and practices, voicelessness in community planning—all conspire to make migrants forgotten citizens when it comes to local provisions of health and other services. Even when States and localities recognize their needs and try to plan for them, great difficulties are encountered. They are here today and gone tomorrow, gone to some destination which is perhaps unknown even to themselves.

Over the years, some migrants have left migratory work in agriculture. They have either been displaced by machines that quickly and easily perform the work of thousands of human hands; or they have found new job opportunities at permanent locations. But the need for a mobile supply of farmworkers to meet the peak labor demands of hundreds of the Nation's agricultural counties continues. Only with a mobile labor supply can the American appetite for fresh fruit and vegetables that do not yet lend themselves to machine harvesting be satisfied. Furthermore, the market for the labors of the migrant force will continue, particularly in the new agricultural areas where there is little or no local labor supply.

The total number of migrant farmworkers and dependents appears likely to continue around 1 million, fluctuating annually according to weather, crop, and market conditions. This estimate excludes at least an equal number of potential migrants who are as poor, as isolated from the community and as deprived of health care as the current migrant. Especially in the homebase counties of Texas, Florida, California, Missouri, Arizona, and New Mexico, the migrants of the past season merge with their equally impoverished neighbors, many of them families who have moved in the past and may migrate again next year.

The best clues to the health problems of the migrant population come from these home-based counties. Here 18 percent of the babies are born at home and the infant mortality rate is conservatively estimated at one-fourth higher than the national average. My own opinion is that it is much higher than that. Parasitic infestations and tuberculosis—conditions associated with poverty, poor nutrition, and poor environment—are common. Iron deficiency anemia is prevalent—and amazingly present. I heard recently some statistics done on migrant labor. Apparently between 20 and 25 percent of children have gross anemia, probably related to what they are eating. Nutritionally based diseases such as beriberi, pellagra, scurvy, and rickets are occasionally found. Dental decay is almost universal.

Yet the counties where the problems are most severe are seriously handicapped by shortages of health manpower to deal with them. The ratios of physicians and dentists to the population that stays in the county; that is, the permanent population, is less than half the national average. The counties as a whole have median family incomes averaging about three-fourths of the national media.

ACCOMPLISHMENTS UNDER THE MIGRANT HEALTH ACT

The Migrant Health Act was devised to make health care accessible to migrants through helping States and communities adapt their health care system to the migrant's unique situation and need. In striking contrast to the half-dozen isolated community efforts of 6 years ago, now 117 single or multicounty grant-assisted projects serve migrants in 35 States and Puerto Rico. They provide actual medical, dental, and related health services in places and under conditions which make them easily accessible. They are used by migrant workers and their families, at home and on the road.

A typical project operates one or more family health service clinics during the season or year round, depending on whether the project serves a northern work area or a home base where migrants move in and out throughout the year. The clinics are open at least once or twice weekly, usually during the evening, so that workers as well as family dependents can use the service. Some projects have mobile units, but most are set up temporarily in churches, school buildings, labor camp units or outlying public health facilities. One or more physicians, nurses, technicians and aides may travel from 10 to 50 or more miles for the evening's work in these clinics.

The clinic sessions bring preventive and remedial health care to the migrants at times and places which make it readily accessible for use. Typically, they are supplemented by arrangements with local physicians or hospital outpatient departments which provide emergency care between clinic sessions. They treat all family members for whatever illnesses, injuries or other needs they present, referring patients for further special care if necessary.

The medical services are supported by an active outreach through nurses and aides who visit migrants in their homes for early casefinding, health counseling, necessary referral, and post-treatment followup Support is also received from sanitarians concerned with removal of health hazards at the home and work sites. These health hazards don't only apply to the migrants; they apply to the people who are going to eat the vegetables.

We encourage participation of migrant families in planning for services to meet their expressed needs and desires. We also encourage project staff members to consider each contact with a migrant as an opportunity for health counseling. Some projects conduct systematic health education programs on a group basis to supplement informal individual counseling.

Nearly 1,000 physicians are now serving migrants through 225 family health service clinics supplemented by care in their own offices or in hospitals. An estimated 325,000 migrants lived in counties served by projects for at least part of the 12-month period ending last June 30. During the year, 210,000 medical visits and 28,000 dental visits were made and 3,600 migrants were hospitalized. In addition, nurses and aides to nurses made 160,000 case-finding and health counseling visits to labor camps, other migrant home sites, schools and day-care centers serving migrant children. Sanitarians and sanitation aides made 120,000 visits to migrant housing for inspection and followup to see that housing deficiencies were corrected. Sanitation staff members are now starting to make similar visits to work sites in fields and packing

sheds to see that toilets, safe drinking water, and water for handwashing are provided.

Migrant health projects provide not only remedial care to all family members, but also immunizations, family planning services, nutrition counseling, and other health maintenance services. Project staff members work with growers and other community groups to improve housing and environmental conditions, and to develop better understanding and acceptance of migrants as people.

Finally, they work directly with migrants, to teach and encourage good homemaking and safety practices, and to provide better understanding of health services and their effective use.

Funds for hospitalization under the auspices of migrant health projects became available for the first time in 1967. Currently, about half the projects provide hospital care in addition to other services under the provisions of the 1965 and 1968 extensions of the Migrant Health Act.

Many communities and individuals have invested their own time, facilities, equipment, funds and other items essential to the provision of project services. An average of 40 percent of project support—in cash and in kind—has come from other than migrant health grant sources.

Within the last month, with assistance from the Public Health Service staff, the national organization of more than 400 orders of Catholic sisters in the United States has adopted a national plan for involvement of their trained teachers, nurses, and social workers in services to migrants. The sisters will volunteer their services through existing projects and will help to organize services where they are deficient. They will be a much needed source of additional professional manpower in needy rural areas where an influx of migrants creates an almost overwhelming problem.

CONTINUING NEEDS

In spite of the progress made, two-thirds of the Nation's 900 counties where migrants live temporarily still have no grant-assisted services. The services provided by existing projects are heavily utilized; however, services provided to migrants in project areas have averaged less than one medical visit per person per year, compared with the national average of more than four visits per person per year. Dental visits per migrant have averaged about one-twentieth of the national per capita average. The amount spent per migrant in migrant health project areas totaled about $12 last year, including funds from all sources, compared with a national per capita health expenditure of about $250.

Specific improvements needed include:

1. Additional family health service centers established in or near large migrant labor camps or other points of migrant labor concentration.

2. Improvement of the quantity and comprehensiveness of dental as well as medical services for all family members.

3. Increased "outreach" services through nurses and aides for case-finding and health counseling. These are terribly important. They interpret not only the doctors' or nurses' instructions to the people with whom they deal, but they interpret the people's cultural attitudes to-

ward health to the doctors and nurses. One needs to know that if one is going to see to it that the health services are used.

4. Increased assistance by professional health educators to strengthen the health education component of migrant health services.

5. Intensified sanitation services to improve migrants' living and working environment.

6. Addition of medical social service, nutrition counseling, and homemaker services.

7. Recruitment from among migrants and ex-migrants of greatly increased numbers of aides to help relieve professional health manpower shortages and to establish more effective liaison with migrants.

8. Improved arrangements for post-hospital followup and services.

Before commenting upon the provisions of the legislation under consideration by this committee, Mr. Chairman—and I appreciate your listening to this description of the migrant state, which I am sure many of you are well aware of—I wish to express my own deep concern and that of this administration with the health problems of the migrant and his family. As evidence of this, and our commitment to the task of improving the health of these people, we are currently considering a number of alternatives which will increase the effectiveness of our efforts to solve the migrants' unique health care problems.

As you know, Mr. Chairman, Secretary Finch has appointed a blue-ribbon task force to review the medicaid program in its entirety. I am meeting with the chairman of that task force and Secretary Finch right after this hearing. I will have very much in mind the migrant problem during that meeting.

This group is currently considering our entire commitment to the migrant worker, and is investigating the possibility of including such persons within the scope of medicaid benefits. Also under consideration is a proposal which would consolidate the migrant health activities of DHEW with the "Partnership for Health" program. This proposal would provide for the setting aside of funds under section 314(e) of the PHS act specifically for migrant health projects. This would be consistent with our desire to consolidate and simplify the present proliferation of grant authorities, yet give the special attention to migrant health that is required. Furthermore, the President's proposed Family Assistance Plan, when enacted into law, will have an impact on the health of migrant workers by increasing the income of migrants, thereby ameliorating that part of the unique migrant health problems caused by lack of money.

Therefore, in view of these new program needs and directions, Mr. Chairman, we support the extension of the existing grant legislation; however, we would like to recommend that the extension be for 2 years rather than for 3, as provided in H.R. 13432. We anticipate that viable alternatives will become evident, and would be appropriate for congressional review within that time. As for the proposed increases in the annual appropriation authorizations, it appears unlikely at this time that prevailing budgetary and expenditure constraints will permit such a rapid expansion in the funding of this program. We would, therefore, recommend that the specific annual authorizations be replaced with an indefinite authorization—that is, "such sums as may be necessary." If that is placed in there, I can assure you that I will join you in fighting for the largest sums we can obtain.

With respect to the remainder of the provisions of H.R. 13432, we do not consider it necessary to provide specifically for grants to train persons in allied health professions since the present language already provides ample authority for appropriate training activities for people to function in migrant health projects. Furthermore, we believe that extending the services provided under section 310 to "other seasonal agricultural workers" would or might tend to confuse the identity of the intended beneficiaries of the program and, therefore, until we can clarify the issues, we recommend its deletion from the bill. We also believe that the term "provide continuity" in subsection (c) of H.R. 13432 is already contained within the concept of "improvement" in the present language of section 310. Hence, we see no need to add the proposed term.

This concludes my formal statement, Mr. Chairman, but my associates and I would be happy to answer any questions your committee may have in mind.

Mr. JARMAN. Thank you very much, Doctor, for an excellent statement. The committee particularly appreciates you and your associates preparing testimony for us this morning on what we realize was fairly short notice, but we are concerned about this program and its extension, and we wanted to fit the hearings into the full committee agenda as quickly as we could, and as soon as a date could be set. We do appreciate your being with us today.

We will certainly give careful consideration to the specific comments you have made on H.R. 13432.

As to the monetary side of it, it has been our position on the committee for a long time that there has been opposition to passing legislation with an open-end authorization provision. We feel in nearly all instances that we should pin down to a reasonable and specific amount the area within which programs should operate.

The authorization for 1969 was $9 million, and the final figure agreed on for 1970 was $15 million. This bill would increase for 1971 to $30 million, for 1972 to $45 million, and $60 million for 1973.

Under the existing program, have you been able to use the full amount of the authorization of the 1967–70 fiscal years?

Dr. EGEBERG. The 1969–70 authorization was $9 million, as you said.

Mr. JARMAN. Wasn't it $15 for 1970 as finally agreed to?

Dr. EGEBERG. Were you asking me about 1970?

Mr. JARMAN. It was $9 million for 1969, as I remember, and $15 million for 1970.

Mr. CAVANAUGH. $15 million for 1970, Mr. Chairman. The administration actually did request the full $15 million. Could I give you the history of this for a moment?

As you indicated, in 1969 the authorization was $9 million and the amount appropriated was $8 million. The previous administration requested $12 million in its budget for this fiscal year. President Nixon increased this budget request in April up to the full amount of the authorization; that is, $15 million.

However, as you know, the House in the House Labor-HEW appropriations bill, provided only $8 million. We did come up and ask for the full $15 million, which we feel could be used and used very wisely, but the House Appropriations Committee did not see fit to grant us that full amount.

Mr. JARMAN. Are you in a position to indicate to the subcommittee, either today or projecting ahead, as to what you think that funding limit should be in specific amounts for the next 2 or 3 fiscal years? Are you in a position to comment on that today, Doctor?

Dr. EGEBERG. All I can say on that score is that things would appear to be carried out in proportion in Government, and one fights for one's biggest share of that proportion. I feel the need is great. We will give you specific figures, if you would like, later on. In the meantime, we would appreciate the $15 million during the current year.

I am sure that our budget request is an indication of the President's attitude toward the health of migrant laborers, and would imply that he will ask more next year, but if you wish our estimates, we will get that for you. When do you need it? Before a certain time?

Mr. JARMAN. Well, of course, the subcommittee will meet in executive session as soon as we can on this bill, after we have completed hearings. Then we would be in a position to report the bill to the full committee. So if in the next few days you could do that, it would be helpful, particularly so in view of the fact that in your statement, with reference to the bill, you do point out that it would appear unlikely at the present time that the prevailing budgetary and expenditure restraints will permit such a rapid expansion in the funding of this program.

It would be helpful to the committee if you could be as specific as you can be in terms of what you think can be done within the next 2 or 3 fiscal years.

Dr. EGEBERG. This relates in some measure to what we think we can get out of medicaid and other sources, which is apparently the trend that they want us to follow.

(For the information requested see letter dated Oct. 9, 1969, p. 13.)

Mr. JARMAN. Thank you very much. Mr. Rogers?

Mr. ROGERS. Thank you, Mr. Chairman.

Mr. Secretary, it is good to see you before the committee. I know of your efforts in trying to improve the health of the American people. In an overall view, I know the President has said there is a crisis in health. I think Secretary Finch has also made statements to that effect.

Yet overall, I don't see the emphasis being placed on health in the Department that would coincide with this description of a crisis in health. What is your feeling about what we are doing? Are we really responding to the crisis in health or should we be doing more?

Dr. EGEBERG. We have to do a lot more. First, I feel we have to learn some of the facts. There have been quite a few facts available. I am aware that some of the facts aren't facts. I would like to assure myself what the various situations are. Then within my ability to do so, and my ability depends on my relationship, I suppose, to the Government, to the Congress and so forth, I shall try to get that amount of money that is necessary to begin to meet the crisis. I don't think we can meet it immediately. I think we have to plan and look forward.

Mr. ROGERS. The plan that has been projected—although I don't know if it has actually been accepted—the 5-year plan, is not very encouraging, because it only talks about a moderate approach here and not a crisis level approach.

This is what concerns me. I don't think we are really projecting a sufficient amount of activity to meet the crisis that the President himself has designated.

Dr. EGEBERG. I will see if I can't make a crisis. Also, that projection isn't an official one. It hasn't been accepted.

Mr. ROGERS. I hope not.

Dr. EGEBERG. That is what I mean by "I will make a crisis."

Mr. ROGERS. Good.

I hope that is not a true projection of the Department's response to what I think is truly a health crisis in the Nation.

I think your statement is good until you come to the conclusions of what the Department will do. I think you have set forth the problem. I think you have expressed very dramatically the dire need that migrants have for health care. I know this to be a fact because I have witnessed it, as I am sure many members have, all over this country.

I see underlying here the position that maybe we are going to take care of them through medicaid. How many States participate in medicaid?

Dr. EGEBERG. About 40; 44 to be exact.

Mr. ROGERS. So some of them don't. For migrants in those States that do not participate, that will not be very helpful. Are all the States participating alike in medicaid?

Mr. CAVANAUGH. No, they are not.

Mr. ROGERS. Do the programs vary?

Mr. CAVANAUGH. The programs vary substantially at this point in time. If the initial intent of the legislation is carried out, in the Social Security Act in title 19, there would be uniform base coverage by 1972.

Mr. ROGERS. By 1972?

Mr. CAVANAUGH. That is correct, sir.

Mr. ROGERS. This bill covers until when?

Mr. CAVANAUGH. Your bill would extend the program for 3 years. This bill would extend it for 2 years. During that time, as Dr. Egeberg stated, the Department would be reviewing various alternatives and approaches, including title 19, including the impact of the family assistance program, and including, perhaps, additional funding under the 314(e) mechanism.

I might point out that a fourth alternative would be a further expansion and perhaps for a longer period of time of something similar to the current program.

Mr. ROGERS. Actually, this bill goes into fiscal 1973, doesn't it?

Mr. CAVANAUGH. Yes, sir.

Mr. ROGERS. 1971, 1972 and 1973. So it is going to take some time to get Medicaid going, getting States to agree to change and meet standards, I presume. To what extent, then, would migrants be helped by that program?

Mr. CAVANAUGH. It could very easily provide the financing mechanism for the migrant health worker to purchase and receive health services. I think, as you know, certainly, from your experiences in Florida, that this would present problems in some counties where there are not organized health services available that the migrants have access to, even if they did have a financing mechanism.

We do have to provide some sort of support to organize health services in those areas. I would think that our study over the next year will certainly take that into consideration.

Mr. ROGERS. When you say "study," actually we know already these deficiencies, don't we? We know that there are 600 counties where

basically we are doing nothing to help in this area. We are helping in about 300. We know this. We don't need to study this any more, do we?

Mr. CAVANAUGH. I don't think there is any question, Mr. Rogers. We don't have to study the need. What we do have to take a look at are the various alternatives for meeting that need.

This administration certainly staked out the needs. We increased the budget request by 90 percent over what was made available by the Congress last year and for the first time came up here with an appropriation request amount equal to the authorization.

Mr. ROGERS. I commend you, and I hope when final action is taken it will be up to that figure. I hope the Senate will hold the figure and then we can get it into conference. I will certainly do everything I can to see that that is done, and I think other Members will. It is needed.

I am delighted with the Department's position in that matter. As you review this program, I hope the Department will perhaps review your recommendations on this legislation so that by the time, maybe, that we get this to the floor, you can give us information that will help us in some areas.

For instance, I don't really believe we are at a state where we can turn this over to a partnership for health, do you?

Dr. EGEBERG. No.

Mr. ROGERS. I would agree. It is not possible.

Dr. EGEBERG. I think we can get real help from a partnership, though.

Mr. ROGERS. I hope we can. But we know it is not at the status now to be turned over to the partnership. It has to be categorized from the very nature of the people who are in the program. It is a Federal problem, moving from one area to another.

Let me ask you this: When you go out into a field and there are seasonal workers there, and this one has a disease and the one next to him has a disease, they are both making the same amount of money, living in the same area, but one, actually, is a resident by definition, legal definition, and one is by legal definition a migrant. He is going to move, maybe, in a month or two. But they both have the same disease, the facilities are the same and we are going to help the migrant but we are not going to help the other one. Can we rationalize this?

Dr. EGEBERG. I have been trying to get an answer to that question and I find that for one thing the definition of "migrant" seems a bit diffuse. Too, they feel that if a man is recognized as a legal resident of a county he has access to other health care.

Mr. ROGERS. If it exists in the area and if he has the money or if they have a sufficient program.

Dr. EGEBERG. That is what I am trying to find out. I realize that access is one thing, when it means come and get it, and sometimes you can't do that. I need more information on that.

Maybe Dr. Cashman can help on this.

Dr. CASHMAN. Certainly, Mr. Rogers, in the home-base areas it is a very difficult problem, as you know, to ascertain the difference, because someone who may have been a migrant last year isn't this year, but will be next year. So it is certainly incumbent to prepare the worker for his task next year.

I think a loosely worded definition, however, might open up the whole program to the needs of all the rural people of this country and when our resources are so small, this might further cloud the issue.

Mr. ROGERS. I could share that concern, but what would you suggest as a first start to try and get at this problem? How would you confine it to home base or similar areas?

Dr. EGEBERG. I think more resources, more money, would enable us to handle the home-base problem a little better.

Mr. ROGERS. I mean in the definition that I want to get into. Suppose the committee said we want to start on this problem. Maybe we can't approach it all at once but we want to start on it.

Should we start at the home-base area?

Miss JOHNSTON. I think the problem of distinguishing between the migrant and nonmigrant seasonal farmworkers is really most acute in the home-base area.

As you know, in many of the northern work areas the people do live in camps, and they are easily identified as migratory because of their segregated living in facilities that are only open during the season. When they get back to south Florida or south Texas, or some of the counties in Arizona, New Mexico, and California, they really merge with a much larger population that is engaged in seasonal farmwork.

It should be the responsibility of these home base areas to help the people to prepare to migrate in the next season. But in those areas nobody knows who is going to migrate in the next season. They do know who left last year, but the decision of whether or not to migrate may be made by a seasonal farmworker on the day that a crew leader drives up with his bus and says, "Who wants to go north with me?"

Mr. ROGERS. Suppose we put language in the bill that it would be the intent of the legislation that these services be extended to seasonal migratory laborers in the home-base areas, as so designated by the Secretary?

Miss JOHNSTON. Leaving in the wording that the legislation would continue to apply to migratory farmworkers?

Mr. ROGERS. Yes.

Miss JOHNSTON. Yes.

Mr. ROGERS. But include also your home-base seasonal agricultural workers.

What would be the reaction to that?

Mr. CAVANAUGH. I think, Mr. Rogers, that we would take a good, hard look at the implication of that. I think the fact that the Secretary could designate which areas it would apply to would be very good because this would allow us to tie it into title 19, financing if it were available.

In States where it was not available, it would provide the flexibility to more directly approach the migrant problem.

Mr. ROGERS. In an acute problem, you could go in there. Would you submit language which you think would be acceptable to the Department in that area, which would give you that flexibility?

Mr. CAVANAUGH. We would be very happy to.

(The following letter was received for the record:)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
OFFICE OF THE SECRETARY,
Washington, D.C., October 9, 1969.

Hon. JOHN JARMAN,
Chairman, Subcommittee on Health, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: It was a pleasure to appear before your subcommittee on Monday, September 29, 1969, to testify on H.R. 13432 which extends and amends certain provisions of section 310 of the Public Health Service Act.

During the hearing we were asked for our suggestions with respect to (1) a more limited extension of eligibility for services than is in the bill and (2) specific dollar appropriations limitations—assuming the Committee wishes to amend the existing program in this way. Our suggestions are as follows:

1. With respect to the extended eligibility language ("and other seasonal agricultural workers")—while we are not prepared to offer specific language, we would suggest inclusion, instead of this provision of the bill, of an amendment to section 310 of the Public Health Service Act authorizing the Secretary, in accordance with regulations, to permit the use of grant funds appropriated pursuant to this section to provide health services to persons, other than the migrant workers and their families now covered, when he finds that the provision of such services will contribute to improvement of the health conditions of migrant workers and their families.

2. Possible dollar limitations (subject, of course, to the current fiscal situation) on appropriations authorizations: 1971, $20 million; 1972, $25 million.

I hope these suggestions will be helpful to your Committee.

Sincerely,

ROGER EGEBERG,
Assistant Secretary for Health and Scientific Affairs.

Mr. ROGERS. I will not pursue further questions at this moment, Mr. Chairman. Thank you.

Mr. JARMAN. Mr. Nelson.

Mr. NELSEN. Thank you, Mr. Chairman.

I noted one of the points you mentioned was nutrition counselling. In our area, we have many migrant workers coming into the beet fields. Of course, the almost traditional experience seems to be that this group of people like that type of occupation. They seem to move with the harvest.

Naturally, they live in an area only a very short time. Therefore, housing is always a problem and is rather expensive because of the short load factor of the investment.

The nutrition matter seems to be a pattern that is hard to break because it is a traditional sort of thing. Of course, I assume it is a matter of education.

I am sure you would find that to be true as far as nutrition is concerned.

Dr. EGEBERG. Yes. The habits of eating in certain parts of the country, whether they be migrants or people who live there, are appalling, insofar as what the people really need and often could get at the same price.

Mr. NELSEN. I notice the reference to the personnel. You referred to the fact that it is not necessary to include that in this bill because it already is an existing language in the law. Is that true? This is for training personnel to deal with the problems.

Mr. CAVANAUGH. That is correct, Mr. Nelsen.

Mr. NELSEN. Referring to the budget, I note that in 1967, $8 million was authorized and $8 million was appropriated.

In 1968, $9 million was authorized with $8 million being appropriated.

In 1969, $9 million was authorized and $8 million was appropriated.

I do have this to say: So many times we expect of an agency a good deal more than the dollars we appropriate will allow. Isn't this always a problem as far as your Department is concerned?

I wish to point out that sometimes manpower is not available because dollars are not available. The control of the dollars is entirely in our hands. I think this program is a worthy one, but it will be up to us to see that there is enough money there to hire the personnel if we want to do this job.

May I join with my colleagues in welcoming you representatives here to speak to us this morning. We wish to be as helpful as we can be. There are so many necessary programs. We will do our best in this.

Dr. EGEBERG. Thank you.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. Thank you, Mr. Chairman.

I was interested in your statement on page 6 concerning the involvement of 400 orders of Catholic sisters. I was wondering, is this mixture of volunteer organizations with governmental organizations working out? Is that proving to be useful and successful?

Dr. EGEBERG. Miss Johnston?

Miss JOHNSTON. This is the kind of thing the program has promoted from the very beginning. Necessity is the mother of invention. When you have a very, very few dollars to work with, you try to scrounge for any dollars you can find from any source, and for other kinds of contributions including volunteer time, volunteer facilities, volunteer equipment, whatever you can get.

So the relationships established with the Catholic sisters is in line with our general philosophy of program operation. It is extremely encouraging to us to have this kind of national approach to the problem.

The sisters have been involved from the beginning. They have been doing things in many areas. But they have been doing it in a kind of sporadic, unorganized fashion.

Now they want to make their impact felt, so they are going to try to do a better job of organization and approach the problem according to a systematic plan.

The Migrant Ministry of the National Council of Churches has been involved from the very beginning. They were often the force that was behind the organization of migrant health projects.

As you know in North Carolina, the Council of Churches and the migrant health projects have worked very closely together.

Mr. PREYER. I have been impressed with the reservoir of good will that exists in this country, with how many people who do want to help, with how many students come to you and say, "I want to do something. What can I do during my summer vacation?" And housewives, as well as institutions like churches, want to do something.

The real problem is finding some way to channel that energy into specific activity. This might be a very effective way.

I have been curious to know whether it actually does work, when you get groups of volunteers this way to work with a governmental agency such as yours.

Miss JOHNSTON. It does work beautifully. I might say, though, that even encouragement of volunteer participation sometimes costs some-

thing, because often the volunteers need the same kind of orientation to the migrant situation that you need to provide for the paid employees.

There is a type of cultural shock for people who go into the migrant camps for the first time. You need to prepare people for that. You need to help them understand how to relate to the migrant in order to work effectively with him.

Then there are problems of transportation, too. Sometimes people can volunteer their time, but they don't really feel like volunteering a lot of costs of transportation to get, say, from Washington State down to Texas where the need is at the moment, where the needs for personnel and help are greatest.

Mr. PREYER. It is an interesting approach. This does seem to be the type of program which could draw on this latent desire for service that we find today.

Thank you.

Mr. JARMAN. Dr. Carter?

Mr. CARTER. Thank you, Mr. Chairman.

I am happy to welcome this distinguished group here today.

I might mention that the first time I met Dr. Egeberg he was a colonel, General MacArthur's surgeon. I met him in the Sierra Madre east of Manila. That was over 25 years ago. He had lunch with me at the company which I commanded at that time. We visited the front lines. I remember hitting the ditch when we came under fire. Colonel Egeberg stood up. I had been there many times and I thought it was better to hit the ditch when I heard those shells coming.

This is an actual fact, as he can tell you. I thought he was a great surgeon at that time, and I certainly think that he will perform the duties of his office well today.

I am happy to have him in his present position.

Mr. CAVANAUGH. I would like to add to that, if I might, Doctor, for those of us who are interested in moving the health programs ahead in HEW, that we are very happy that Dr. Egeberg is still standing up at those times that the shells are flying.

Mr. CARTER. We will stand up with him.

Thank you, Mr. Chairman.

Mr. JARMAN. Mr. Rogers.

Mr. ROGERS. In the bill on allied health professions, you say there is ample authority for appropriate training activities for people to function in migrant health programs.

How many people are being trained in these fields under the present programs?

Miss JOHNSTON. When the bill was originally enacted in 1962 there was discussion of the training provision in the bill. Essentially this was interpreted as orientation of the people who were to function in a migrant health project.

At that time, Congress felt that we should not get into formal training of people for the health professions. So this has been avoided.

Generally, the training through the migrant health projects is limited to orientation of people who are going to function in that project. This goes for the physicians, nurses, sanitarians, all the professional people, too.

It has also covered the training of subprofessional aides. Again, necessity was the mother of invention. There weren't enough health-

workers in many of the areas where migrant health projects have had to operate. So the physicians had to find ways of delegating some of their responsibilities to the nurses, the nurses to the aides, and the health educators to aides.

The aide concept was not very well developed in the health field in the United States at the time the program started, so that the migrant health program in such counties as Kern County, Calif., has been a pioneer in the training of subprofessional aides, many of them migrants or ex-migrants, who are now working in health projects.

Again, in your own county in Florida, as you know, they tried this about 1954 and 1955. They recruited a Negro woman from the migrant population who, I think, taught your own health professionals quite a bit about the migrant population.

At the same time, she was providing service through the demonstration project in Palm Beach County.

Mr. ROGERS. Yes. The reason we put this in the draft of the bill is that we do want to emphasize this. I think it is necessary. Although there may be authorizing legislation as such, it really hasn't been effectively used because it was not clear that we expected this to be done.

That is the reason we hope that this will be used, if the committee includes it. I hope they will. I think this is a special area where we need some emphasis. So much can be done by allied health people in this area where you don't necessarily always have to have the doctor.

I don't think we have taken full advantage of this fact. By training some allied people, we can really cover a much larger area in a very effective way. So I hope the Department will review their position on this particular point, because I think it is important to include it in this legislation as well.

Dr. EGEBERG. I would like to add that I feel very deeply about this, both in solving our manpower problem, and in the case of migrants and also in the case of our slums the culture of the people—every group has a culture—is so different from that of the purveyors of health that they don't understand each other at all.

So this man from the local community, or this woman as it most often is, is able to interpret, as I think I said earlier, in both directions so they can speak to each other.

Mr. ROGERS. That is right. So you are receptive to the idea that if the committee were to include this, you think it could be useful.

Dr. EGEBERG. Yes, sir.

Mr. ROGERS. In conclusion, let me say that I personally—and I am sure this committee also—am looking forward to working with you, Dr. Egeberg.

I hope you will be able to convince the Secretary and the budget people that this crisis that the President has designated in health must be met, and that the health functions of the Department should not be the stepchild of the three.

I know great emphasis is being placed on the welfare program, understandably, and on social security; also education. But I do hope that you will be the one standing up, as I am sure you will be, in the Department and in this administration, because we have to rely on you to be the spokesman for health, to make sure it is going to be at least an equal party in the Department of HEW with the other two, education and welfare.

I am sure this committee, and I believe the Congress, will stand firmly with you under your leadership.

Dr. EGEBERG. Thank you, sir.

Mr. CARTER. Just as I have seen the distinguished physician stand up under fire in the Philippines in the last war, I am sure he will stand up for our health services today.

As a member of this committee, I am going to stand with him.

Thank you, Mr. Chairman.

Dr. EGEBERG. Thank you, sir.

Mr. JARMAN. Dr. Egeberg, I think you can count on the active assistance and cooperation of this subcommittee and of our full committee on the legislative projects that we have ahead of us.

We appreciate very much, Miss Johnston, Mr. Cavanaugh, and Dr. Cashman, your being with us to lead off as witnesses on this very important matter.

The Chair will yield now to our colleague from Florida, Mr. Rogers, to introduce our next witness.

Mr. ROGERS. Mr. Chairman, it is an honor for me to introduce one of the next witnesses, or reintroduce him to this committee.

He has appeared before this committee many, many times. His testimony has always been most helpful. I don't know of any physician who is in the field with a working program who is more knowledgeable in this area of migrant health than is Dr. Carl L. Brumback, director, Palm Beach County Health Department, West Palm Beach, Fla.

They have had pilot programs in this area that are making great progress. I know the information he will give us will be of great help to the committee.

It is an honor to introduce Dr. Brumback to the committee, and I appreciate the chairman's permitting me to do so.

Mr. JARMAN. We are pleased to have you with us, Doctor. We will be glad to receive any testimony you might have.

STATEMENTS OF DR. CARL L. BRUMBACK, DIRECTOR, PALM BEACH COUNTY HEALTH DEPARTMENT, WEST PALM BEACH, FLA., AND DR. WILLIAM J. DOUGHERTY, DIRECTOR, LOCAL HEALTH SERVICES, NEW JERSEY DEPARTMENT OF HEALTH—ALSO IN BEHALF OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

Dr. BRUMBACK. Might I bring my colleague, Dr. William Dougherty, director, local health services, New Jersey Department of Health, with me to the witness table?

Mr. JARMAN. Certainly.

Mr. ROGERS. I might note, too, Mr. Chairman, that Dr. Dougherty has done a wonderful job in this area. His association can always be depended upon to provide information to the committee as it is needed.

Dr. BRUMBACK. Thank you, Mr. Chairman and Mr. Rogers.

Mr. Chairman and members of the committee, I appreciate the opportunity to present my views and those of the American Public Health Association on H.R. 13432, a bill to extend the program of health services for migrant and seasonal agricultural workers and their families.

I speak from the viewpoint of 20 years' experience working directly with agricultural migrants, and also as a member of the executive board of the American Public Health Association.

Having presented testimony to this committee on previous occasions, I will not repeat information which is well known to you. The justification for providing adequate health care to these 1 million men, women, and children is similar to that for others who live in poverty.

But we also must recognize that migrants' needs are compounded and complicated by their moving from one place to another, by their isolation from facilities available to the resident population, and by other problems related to their cultural and living patterns.

It is for these reasons that we urge continuation and expansion of support for special health services conducted through the Migrant Health Act.

The migrant health projects now in operation throughout the Nation are providing desperately needed care for many migratory farm workers. Prenatal care, immunizations, nutrition counseling, family planning services, medical treatment, health education, and sanitation are examples of the services now available.

However, it must be recognized that the number of migrants who still do not receive these benefits is much greater than the number who do receive some service. Even those who are reached cannot be given more than the barest minimum care because of limited staff and funds.

The projects now in operation have largely been developed by careful planning and utilization of all available resources, Federal, State, and local, public and private.

They are wonderful examples of community participation in planning and development programs for health.

A great deal of innovation has been shown in the development of these projects. However, the neglect of generations, cultural barriers, and the unusual problems found among these people cannot be overcome in a few short years.

These projects are just now beginning to pay off on the investment.

I am sure you agree that the funding of these projects has not been sufficient to provide services in proportion to the needs. Lack of money for hospitalization has been a major deficiency, but there are also migrants who cannot even receive outpatient care and preventive services.

H.R. 13432 recognizes the fact that special programs for agricultural migrants must be continued through the project grant mechanism if these people are not to be lost in the shuffle as they have been in the past.

This bill provides assurances that the programs assisted will be specifically designed to meet the migrants' needs. Most important, this bill authorizes funding more nearly in proportion to the number of people needing care and in relation to the magnitude of their needs.

Mr. Chairman, I would like to cite some points from the statement of the American Public Health Association.

I would like to ask your permission also to file this statement for the record.

Mr. JARMAN. Doctor, the statement in its entirety will be received for the record. We will welcome your comments.

Dr. BRUMBACK. Thank you.

The health needs of agricultural migrant workers are greater than those of any other socioeconomic group in the United States.

These people have health problems that are similar to but more severe than those of stable rural farmworker families. Studies continue to show high infant mortality rates, high communicable disease rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, serious need for dental care, low economic and educational levels, mobility, lack of resident status, geographic isolation from medical facilities plus cultural factors and language barriers contributing to the health problems of migrant and seasonal agricultural workers.

In instances where the social, economic, geographic, and cultural characteristics have been taken into consideration and where funds have been made available the improvements in health conditions among this group in various parts of the United States has been most striking.

The need for improved health services for migratory and seasonal agricultural workers has also been recognized by the President's National Advisory Commission on Rural Poverty.

The fact recognized by the Commission and by H.R. 13432 is that migrant and seasonal farmworkers frequently live side by side in the same community. Their status as seasonal workers and as migrant workers shifts and it makes no sense to arbitrarily cut off health services of a migrant agricultural worker when his status reverts to that of a seasonal agricultural worker. We discovered this to be true many years ago and in our own home area.

Justification for the increases in the authorizations for appropriations for the years 1971, 1972, and 1973 are as follows:

The fact that only one-third of the 1 million migrant agricultural workers and their families are now being reached through grant-assisted projects. The addition of seasonal agricultural workers will add an estimated 2 million to the population to be served.

The fact that the estimated per capita annual expenditure for personal health services for migrants last year was less than $11, as compared to national average per capital expenditure of $250.

Migrants' use of medical care is about one-seventh, their use of dental care is about one-twentieth, and their use of hospital care is about one-fourth that of the general population.

The accident mortality rate for migrants is nearly three times the national average.

The mortality of migrants due to tuberculosis, influenza, pneumonia, and other infectious diseases is more than twice the national average.

These deficiencies among migrant workers and their families also prevail among seasonal agricultural workers and their families. If comprehensive health services are to be provided these keyworkers of the agricultural economy, it is essential that appropriations be increased.

Mr. Chairman, again I wish to express appreciation of the American Public Health Association and myself for this opportunity to express our views on this important bill.

Mr. JARMAN. Thank you very much.

(The prepared statement of the American Public Health Association follows:)

STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION

The American Public Health Association wishes to bring to your attention its deep interest in, and full endorsement of, the provisions of H.R. 13432. This legislation would enable the United States Public Health Service to assist States and local communities in their efforts to extend health services for domestic agricultural workers and their families. Favorable consideration by the Congress is urgently needed.

The American Public Health Association, with some forty-five thousand public health workers in its affiliated societies and branches throughout the United States, has for many years been deeply concerned about the serious need for Congressional action to assist in efforts to overcome the nationwide difficulties inherent in the provision of truly available health services to these disadvantaged farm workers. The Federal responsibility for leadership, stimulation, coordination, and support of local health efforts for these people is as clear as their economic importance to American agriculture.

First of all, I want to pay tribute to the author of H.R. 13432. Those of us in the American Public Health Association are very much aware of Congressman Paul G. Rogers' contributions in the field of health legislation. In recognition of his efforts in behalf of the health of migratory agricultural workers the American Public Health Association in 1962 awarded him an Acknowledgement of Appreciation for Special Services Rendered in Advancement of the Health of Migratory Workers. A copy of the citation is attached to this statement in Appendix A. We are very grateful.

In addition, there is also attached to this statement two resolutions approved by the American Public Health Association in behalf of the health of migratory agricultural workers. These appear in Appendix B.

The concern of this Association for the plight of migrant and seasonal agricultural workers and their families is prompted by the following facts:

1. The health needs of domestic agricultural workers, particularly those migrating from their home communities, are greater than those of any other socioeconomic group in the United States. These people have health problems similar to, but more severe than, those of stable rural farm workers' families. Studies continue to show high infant mortality rates, high communicable disease rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, serious needs for dental care, and little realization of the need for or utilization of preventive and early treatment.

2. Low economic and education levels, mobility, lack of resident status, geographic isolation from medical facilities, plus cultural factors and language barriers contribute to the health problems of migrant and seasonal agricultural workers.

3. In isolated instances where the social, economic, geographic, and cultural characteristics have been taken into consideration in offering services to this group, and where funds have been made available, the improvements in health conditions among this group in various parts of the United States has been striking.

The need for improved health services for migratory and seasonal agricultural workers has also been recognized by the President's National Advisory Commission on Rural Poverty. The Commission under the chairmanship of the then-Governor Edward T. Breathitt of Kentucky recommended in 1967 that the Migrant Health Act be renewed with sufficient funds to expand the program in terms of geographic coverage and service offered. The Commission also recommended continuity of services with a broader definition of migrant worker to cover the entire migrant community, especially in home-base areas. The fact recognized by the Commission and by H.R. 13432 is that migrant and seasonal farm workers frequently live side by side in the same community. Their status as seasonal workers and as migrant workers shifts and it makes no sense to arbitrarily cut off health services of a migrant agricultural worker when his status reverts to that of a seasonal agricultural worker. I want to make it clear that the American Public Health Association is fully in support of the extension of services to seasonal agricultural workers as provided for by H.R. 13432.

The increases in the authorizations for appropriations for the years 1971, 1972 and 1973 are modest in comparison to the size of the problem. From the present authorization of $15 million for 1970 the limits would rise to $30 million in 1971, $45 million in 1972, and $60 million in 1973. I would like to cite some data that demonstrates how urgent is the proposed increase in funds.

Only one-third of the one million migrant agricultural workers and their families are now being reached through grant-assisted projects. The addition of

seasonal agricultural workers will add an estimated two million to the population to be served.

The estimated per capita annnal expenditure for personal health services for migrants last year was iess than $11 as compared to national average per capita expenditure of $250.

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The accident mortality rate for migrants is nearly three times the national average.

The mortality of migrants due to tuberculosis, influenza, pneumonia, and other infectious diseases is more than twice the national average.

These defieiencies among migrant workers and their families aiso prevail among seasonal agricultural workers and their families. If comprehensive health services are to he provided these key workers of the agricultural economy, it is essential that appropriations be increased.

We are fully in support of section (e) of H.R. 13432 that emphasizes improved health services with continuity of care as well as improved health conditions.

We are also fully in support of section (d) of H.R. 13432 that emphasizes the training of aiiied health professions personnel. Our Association recognizes that we can substantially improve our utilization of health manpower. Some medicai schools are experimenting in training assistants to physicians to increase their productivity. The use of such personnel should be encouraged in the migrant health program.

In concluding, let me express the appreciation of the American Puhlic Health Association for this opportunity to express our recommendations on H.R. 13432. We urge its enactment.

Appendix A

Acknowledgement of Appreciation to Congressman Paul G. Rogers for Special Services Rendered in Advancement of the Health of Migratory Workers, 1962

The unfortunate plight of domestic migratory agricultural workers and their families has long been a problem of this Nation. For many years, public health workers have been concerned abont their snbstandard health status and about the problems faced by communities in organizing and providing adequate health services for this group.

In 1959, the Amerlean Public Health Association urged the Congress of the United States to accept the responsibility of assisting States and local communities to provide these needed health services in an organized and systematic fashion. Through such programs, migratory workers would have an opportunity to benefit from the many advantages of modern public health, and our agricultural economy, to which this human resource is essential, would be improved.

Through the enactment of Public Law 87–692, the Congress has made a significant contribution to the solution of the health problem of the migrant worker and his family. By his support of this legislation, CONGRESSMAN PAUL G. ROGERS has contributed greatly to a forward step in public health. For this contribution, the American Public Health Association is extremely grateful and wishes to express its thanks and appreciation by awarding the accompanying certificate of appreciation.

October, 1962.

Berwyn F. Mattison, M.D.

Appendix B

Resolutions Approved by the American Public Health Association on Behalf of Migratory Agricultural Workers

MIGRATORY LABOR

Whereas studies in various parts of the country disclose great need for the development of comprehensive health services to the migratory worker and his family, especially the migratory farm worker, in concert with other community services such as those for welfare, education, and employment, therefore be it

Resolved That the American Puhlic Health Association recommend the establishment of Governors' advisory committees on migratory labor composed of individuals best informed ahout the fields of health, housing, welfare, education, and employment, and be it further

Resolved That the American Public Health Association request the President and the Congress of the United States to provide adequate financing for the continuation and strengthening of Federal services through the Department of Health, Education, and Welfare directed to migratory workers and their families, including grant-in-aid programs to appropriate state agencies.

Approved by the Governing Council American Public Health Association, October 21, 1959.

AGRICULTURAL MIGRANCY

In many of the States there are sizeable numbers of agricultural migrant laborers. Presently, many benefits available to other citizens are inaccessible or denied to the migrant. Migrant children are precluded from adequate basic education and preparation for improved vocational opportunity. Competition offered by labor imports from countries with lower standards of living has served to depress domestic farm labor opportunities and standards of living and health.

The American Public Health Association, recognizing that the migrant laborer's health and well being are parts of a broader issue regarding the total migrancy problem, requests the President of the United States to appoint a National Task Force on Migrant Agricultural Labor to:

1. Examine the problem from the point of view of labor, industry, agriculture, and community residents.

2. Stimulate the application of existing knowledge in the improvement of the health of migrant agricultural workers and their families.

3. Consider ways of utilizing new technology and other measures in the elimination of migrancy in the Nation's agricultural manpower pool.

In the interim, the American Public Health Association urges State and local health officers to develop and strengthen health programs for the agricultural migrant and his family and to seek solutions to problems of residency requirements.

Approved by the Governing Council American Public Health Association, October 20, 1965.

Mr. JARMAN. Dr. Dougherty, would you have any additional comments?

STATEMENT OF DR. WILLIAM J. DOUGHERTY

Dr. DOUGHERTY. Yes, sir. It is a pleasure to come and a privilege also to speak as a direct representative of a local health services operation, State of New Jersey, and for the American Public Health Association in behalf of H.R. 13432.

I would like to say, before I delve into the subject matter of my presentation, that a word of recognition should be extended to the person who has provided the essential initiative in HEW for a number of years, and I am sure that without the dedication and dynamic effort of this woman, the impact of the legislation might not have been as well felt in this country. She has contributed immensely.

Mr. JARMAN. That is a very fine tribute.

Dr. DOUGHERTY. I might say also I will not belabor the presentation of need. I think it has been adequately documented here this morning in your statement, Congressman Jarman, and the statements of HEW and text of the other statements.

I do think in looking at the practical application of this bill, that it brings to light a deficiency that has existed from the very beginning. If we consider the issue of migrants from Florida, Puerto Rico, Texas, Southern California, Arizona, and New Mexico to whatever other point you may wish to choose, the impact of the lack of health services in one part of this country upon the other is clearly recognized.

In New Jersey, I have been associated with this program since 1956 in one way or another. First it was as a district State health officer and then director of preventable disease and as assistant commissioner for health services and directly involved also as a director of a project.

Let me say in a local sense if you are in a serving agency such as a nursing association, a social service agency, possibly even a health department and possibly even a hospital, when a person who is a migrant comes to you, there is always the question "Why didn't someone else take care of him?"

There is also a question that you have to think about seriously: the ease with which that person can be rejected and the ease of which he can be sent to the hospital, so to speak.

So therefore I am making a positive plea for this bill with the idea that it meets the basic need of putting the emphasis upon health services and the preparation of the individual in the home-based area. I think that the amounts of money you have specified are very large; there is no question about that. The need is also very large in many of the rural areas, States, and Commonwealths.

I also recognize the validity that one has to consider in weighing the efforts of the urban health problem as against the rural, but I would again plead for your concern for the substantive improvement in increase of services in the areas of supply rather than demand.

I also would specify pretty carefully my feelings about your choice of words "a permanent and separate identity" as contrasted with immersion into the area here. I think your attitude is important; I think there is a relationship in terms of attitude and dollars, first at the local level, where fundamentally money for immediate support of health services to nonresident people is relatively quite scarce, depending upon the property tax base, et cetera.

I can assure you from experience in my own State, which we must say is well fixed economically, that there is little money for migrant health services. From this point of view it is felt that this is a national type of activity, so therefore I feel that if this is to be carried out, there has to be a strong catalyst and that strong catalyst can be separately identified Federal program that has the responsibility to stimulate and to extend services to the 600 uncovered counties. My daily work is with county governments and they are very hard to persuade in behalf of the short-time nonresident transient person who is here today and gone tomorrow.

The comprehensive health planning, I believe, as I have watched it, is a good theory, but at the moment it does not have maturity or practicality.

Relative to medicaid, I think the experience as observed by a number of people in a number of States is leading to an increasingly cautious attitude toward the expenditure patterns of medicaid.

Now, our relationship in public welfare with the category of assistance programs has been not the best, primarily because residency and transiency—these factors limit the immediate response that is necessary to serve the migrant.

In other words, his problems are emerging and they cannot be delayed.

I would respond to the training authorization portion of this bill by saying that the orientation of people to the migrant program has been

effective in stimulating a great many individuals who, normally speaking, might never have thought of the issue, might never have given it consideration.

You might have empathy for the migrant and courage to be his advocate before the community agencies and so forth, but he is gone the next year.

My plea would be that some limitation on the training effort be developed. We have a tremendous source of trained manpower in our military personnel who have been through the military schools, and I believe it is a creative demonstration of what we can do with funding in this area.

It would be well for the home-based States to develop programs in which we utilize discharged veterans to work in this type of area and carry with them the basic skills which they have learned in the military.

I know that we in our own area would very much like to find ways and means of bringing such people to bear on the problems of sanitation, health screening, and so on.

I might point out several other things that have to be dealt with, and one is the issue of transportation. In many instances, the professional gets a little disturbed when he has seen a patient he indicates he wants to go to the hospital, and then he must be diagnosed before he gets treated, but to get to the hospital might be 5, 10, or 15 miles. We have worked now on the issue of ongoing transport facilities in several of our rural counties with first demonstrations and then hopefully with the kind of support for both seasonal and migrant workers that such transportation facilities can be continuing.

The issue of nutrition has been brought up. I will not debate findings in terms of nutritional problems. I think the issues are those of ready availability of the food stamp programs to the migrant worker. I am not convinced that we or the agencies have made all of the effort necessary to make them readily available. There is a hang-up really in obtaining these stamps because you need money and if you are not working and not earning, there is no money in your pocket and they are difficult to obtain.

The distribution of simple commodities has never really faced the issue of getting the service to the migrant worker on a short-term basis.

Finally, I think—and I am pleased with this—namely, that in health there are emergencies in nutrition that come about when at times work is short, when rain has interrupted harvest, when strikes have interdicted an activity of harvesting, and the normal earning process does not take place. We have had families in camps where food supplies become actually short because of primarily no money. The farmer has not been able to take care of the problem, and local welfare has not immediately responded to the need; so therefore I believe there should be authorization for food, in an emergency status.

I might say the development of health facilities in association with this program, clinics in the evening, has been really stimulated by the migrant activity, and I think that this carries over also the services to the urban deprived as well.

Now I am going to read a paragraph in this report of the New Jersey effort which took place last year and terminated last year. A great deal of stimulus came from the health activities of the State. In the annual message of the Governor, he proposed legislation that every citizen has

the right to expect that the common carriers transport him to and from work and be adequately maintained and rigorously inspected.

The New Jersey constitution states it reserves the right of, for instance, private employment to organize for the purpose of collective bargaining, that you will submit a proposal to insure this right; the existence of legal restrictions has often served to deny these workers or migrants the simple right to have visitors, and I therefore ask you grant a statutory right to reasonable visitation.

These have come about because of the interest not only of the health people in the State but also of the people that have joined with them and worked with them over the years. These are substantial changes. They go beyond the health. They go into the social and economic health of the individual worker with whom we are concerned.

I wish to thank you.

Mr. JARMAN. Thank you very much. We appreciate both statements. Now we have the problems in the legislation before us. Mr. Rogers.

Mr. ROGERS. Thank you. I want to also express the thanks of the committee along with the chairman for two excellent statements. I think it might be well, too, if each of you could give us some specifics. For instance, I know the program in Palm Beach County provides for the inspection camps and establishing of sanitary standards and an overview of the health situation.

I think the committee would be interested in knowing the specifics of how this program is really getting to the health problem of migrants in your jurisdiction. Give us some examples of what you found. Give the committee the specifics of the program.

Dr. BRUMBACK. Thank you, Mr. Rogers. There are two broad areas concerned, of course—personal health services and environmental health services. The environmental health services which Congressman Rogers just mentioned have certainly received, I would say, equal attention with the personal health services.

Mr. ROGERS. This is in Palm Beach County?

Dr. BRUMBACK. Yes, Palm Beach County; we have a number of camps, and actually the number of required housing arrangements for agricultural migrants goes up into the hundreds in different specific camps, boardinghouses, and those types of facilities, which have to be inspected.

Some of these, as you mentioned, were in such terrible condition they had to be closed down. Of course, we had a debate there about where the people were going to live. This was a very difficult problem. With the cooperation of growers and the cooperation of the migrants themselves working with the health people, these facilities have been improved considerably.

I might say however, that this could not have been accomplished without the help of the Migrant Health Act. It just would not have been done. Some have said that this is a State and local problem. It is, we need the additional force of this legislation to do the job and hire the educators we have employed. It is not just a matter of asking or requiring the grower to upgrade his facilities but it is a matter of educating the migrants themselves and seeing that the farmworkers take care of the housing facilities that are provided. This job could not have been done without the help of the Migrant Health Act.

Without these special funds, this work would not be maintained, I am sure, at the level it is now.

Mr. ROGERS. Now you continuously are inspecting these houses?

Dr. BRUMBACK. Yes.

Mr. ROGERS. And this enables you to continually inspect them?

Dr. BRUMBACK. Yes; it is more than just a process of inspection. I want to bring out the educational aspect and also the training aspect because a lot has been accomplished through training of indigenous personnel; that is, migrants themselves. Some are volunteers and some we were actually putting on the staff and they work on the sanitation staff and with clinics and this is an important thing to us, to use these people themselves. They are more effective in many ways in doing some jobs than professionals themselves.

Mr. ROGERS. I believe you have a mobile clinic—are you trying to locate clinics in areas that are accessible? What do you do in this activity?

Dr. BRUMBACK. Yes, we do. We have not only fixed clinics but we have clinics that move around into the various areas where the migrants are. We try to have the services available for the people so they are accessible to the people. This means we have to have night clinics also. We believe that we should have at least as many night clinics as we have daytime clinics.

Here again it is a matter of having sufficient personnel to do this job. We have been able to, in addition to taking care of the problems in the daytime, having these services available and accessible at night when these people are not working.

Mr. ROGERS. Now you use only public health doctors or do you arrange for contract services for doctors in the local area to come in?

Dr. BRUMBACK. I am glad you brought that out, Congressman Rogers, because this is a very strong point. This program has been developed right from the start and that means back in the early 1950's, in cooperation with our medical profession. I went to the county medical society and I got the unqualified support of our physicians. Most of the clinics are manned and staffed by private physicians doing this on a part-time basis. Most of this is paid. We pay but we actually don't pay in proportion to the demands on these physicians for their time.

Some of them travel long distances. We have some doctors who, for example—pediatricians and general practitioners—who come up from Miami, and they are Spanish and it explains why we need them in the Spanish-speaking area.

Mr. ROGERS. What about New Jersey? Did you operate in a similar manner?

Dr. DOUGHERTY. To a great degree. I have some points on a practical, everyday matter. I am saying sanitation of the environment is probably the first thing we look at in a local public health program. When one looks at a 1,500-migrant labor camp in New Jersey, you would have been appalled, I think, 3 or 5 years ago at the lack of sanitation in these establishments.

Mr. ROGERS. This bill enables you to go in and upgrade the facilities?

Dr. DOUGHERTY. This has done two things: provide us with the level of management necessary; in 1967 the Governor signed a new law, amendment and modification of the existing act, which required a water supply and effective subterranean sewage disposal system to be installed by January 1, 1970.

Last year 1,544 migrant labor camps were applied for and were inspected in terms of their water supply. This meant a physical inspec-

tion of the structure of the well and the appurtenances thereto plus bacteriological testing.

This was a joint operation of the Department of Labor and Department of Health, and we in turn used existing county health departments and municipal health departments, and where there were no such structures, we used the district personnel who are consultants to the local public health agents.

The important thing in this progress in the past year was that only four camps actually failed to meet the requirements for satisfactory supplies.

Mr. ROGERS. What did you do in the four camps?

Dr. DOUGHERTY. Our personnel are available only to those camps. So therefore in order for them to serve, they must do something. Our personnel are available to them for consultation to assist them in the nature of the defect and to show them how to remedy it.

At the present time we are planning a massive operation to survey the existing camps for their subterranean sewage disposal facilities. We know very well if you put in a shower, we have a requirement for hot and cold water and shower facilities, et cetera, but we have still the outmoded privy.

You have the facilities and you have waste disposal, and you have to get it in. It can be done two ways: on the surface or properly engineering and developing a system. Now we are concentrating on that effort. I have no way of knowing at this moment how many camps have flush toilets and sewage disposals, but we will know by the end of this year, and every farmer is faced with the necessity of actually providing these facilities by January 1.

Mr. ROGERS. Let me ask you this: Do you check into the business of whether they have facilities, toilet facilities out in the field, for instance? Suppose they are taken out where they work, they don't come back to their camp until the end of the day; is there any authority for us to get into that area?

Dr. DOUGHERTY. We could, sir, under the provisions of the authorization in the State Migrant Labor Act, actually observe these farms. I might say that our farms are not large farms, they are not tremendous in size as has been described with Imperial Valley and other parts of the country; they are rather small areas. Manpower may not be in the field for protracted periods, only when there is massive picking. So therefore the need for portable sanitary facilities is not as great.

The Department of Labor has insisted where there is long-term activity that portable privy facilities be available. We have gone into efforts of contracting with sanitary agencies to do this work.

Mr. ROGERS. Yes. What about our area? Are we approaching that problem at all?

Dr. BRUMBACK. The problem?

Mr. ROGERS. Where they take them away from the camp for some distance and perhaps they will stay there all day.

Dr. BRUMBACK. Yes. Well, the field sanitation problem is a big one, and we are not really meeting it adequately: however, we are doing some of the same things Dr. Dougherty described in New Jersey. The scope of the problem, the fact that we are dealing with so many people—and by this I mean in Palm Beach County alone, some 35,000 men, women, and children, migrant workers and members of their families

at the peak of the season last year, with approximately 26,000 workers—the problem is so tremendous that it is very difficult to deal with.

But we are working with the field problem and trying to support them with facilities.

Mr. ROGERS. I would be interested in following that up. I would think this is a very important phase and something needs to be done from what I have heard.

Dr. DOUGHERTY. May I present some information on this, because we have provided for two different types of people: One, the contract Puerto Rican worker who is a single male that does not bring the family; this group of men, I think, are explorers: they come to look at the labor situation in another part of their Nation; and shortly thereafter many of them will come and bring their families and they will come as independent people, so therefore we have family problems as well.

The person who comes to Florida, a southern migrant, frequently, traditionally has come with family problems. We first look at the problem on family services, and when we first looked, it was apparent there were pregnant Spanish and Negro women not receiving prenatal care. With the aid of the maternal and child health program, local agencies would evolve a program to bring them the care for prenatal periods. But the key to all of this is delivery service, so a contract was entered into with hospitals of the migrant area. Last year 104 women received prenatal care and there were 42 deliveries in New Jersey hospitals, at a cost of $11,700. We are concerned about such things as per diem cost, $40 or $68 a day for such care.

I might add one more point which I think I can add at this point: namely, that physicians who served in the hospitals for the care of the infant subsequently—namely, the obstetrician and pediatrician—none of these men, according to the New Jersey custom in past years, have ever been reimbursed for their services.

We know full well under the impact of medicare and potential impact of medicaid the physicians will be paid where those people are privileged to receive these services, and therefore if the migrant is not within the medicaid group, that obviously the doctor will say, "I am paid by one program by the Federal Government," and on the other hand they will say to us, "Why should we not be reimbursed for services to migrant workers?" I can see this coming.

The second point is that in some of the areas where migrant workers exist, the care in obstetrics is very limited.

Mr. ROGERS. Thank you.

Mr. JARMAN. Mr. Carter.

Mr. CARTER. Thank you, Mr. Chairman. You mentioned treatment of migrant workers. Do you have cases where they refuse to treat migrant workers?

Dr. DOUGHERTY. We can't document an absolute in this sort of thing, but patients have gone to outpatient departments and have been refused and told to return to camp and asked to return perhaps on another day. The interplay between people is: "How do you deal with a person that invites you either to come or stay away?"

Mr. CARTER. Do you have contract physicians?

Dr. DOUGHERTY. No, sir.

Mr. CARTER. I regret that physicians don't treat all patients. Of course, migrant workers do present serious problems in the areas to which they go. Do you have a program of immunization for these migrant workers when they appear at certain camps?

Dr. DOUGHERTY. Yes, sir.

Mr. CARTER. Do you check them and give them cards to show that they have received immunization?

Dr. DOUGHERTY. Our records now indicate that children, those that have gone into schools, do not come back year after year for immunizations. But in the very beginning some children received so many immunizations that they were overimmunized.

We have records on youngsters that repeatedly come 3, 4, or 5 years into the school system—each summer—and their records for immunization are complete. Not only that but in the dental area they have received not only prophylactic therapy—ordinary cleaning and so forth—but fluoride applications.

This is our aim.

Mr. CARTER. You do have records to determine year after year in the migrant camps?

Dr. DOUGHERTY. Particularly on the school programs, yes.

Mr. CARTER. Only in the school programs?

Dr. DOUGHERTY. These are the best and most authentic records, because we know if a child has been there for 3 to 5 years, then his parents have been there as well and we have the family-related experience of this group for a period of time.

Mr. CARTER. But as far as direct contact with the migrant camps, you have families out from the school authority?

Dr. DOUGHERTY. Our problem is to identify each one of the 25,000, roughly, people scattered over the entire State, and we have not found a proper system for identification of individuals on an individual basis.

Mr. CARTER. It seems to me you ought to issue identification cards so when they come back they will perhaps have a record of their immunization.

Dr. DOUGHERTY. We are working in that direction, using the social security number, because this is probably the most valued possession which the migrant has today. If he is earning and if his wages are being handled in a way that puts him into the social security system and if he understands it, he will safeguard this number.

So each one of the migrants we serve is asked to provide a social security number, which provides him with two stimuli: If he does not have it, we ask him why. Second, it provides an ongoing means by which you may recognize him again.

Mr. CARTER. I notice in your written statement you have "prenatal care," and how many cases of prenatal care?

Dr. DOUGHERTY. Over the season, 104 pregnant women.

Mr. CARTER. The entire cost was $11,000; is that correct?

Dr. DOUGHERTY. That is correct. That was reimbursed from the State funds.

Mr. CARTER. Do you know what the cost of those deliveries and postnatal care for the particular people were?

Dr. DOUGHERTY. No, I don't have that data.

Mr. CARTER. I was interested in your alluding to paramedical personnel for military. I agree that that is a source of trained personnel which you should certainly use.

You also touched on nutrition of these people or lack of it. Do you think the level of nutrition of the migrant worker is quite low?

Dr. DOUGHERTY. As far as the migrant worker who has a certain degree of financial support behind him, it is high as against a person who comes into the system in a transient way and then disappears.

The children—and this is our best indicator—we have observed year by year over the period of their school experience to seemingly improve in weight gained, in their attitude toward the functioning activities of the school. In other words, I might point out that a malnourished child, for instance, is dull, a malnourished child reacts with less spontaneity, and in the program the teachers indicate as the school lunch program continues they do indicate an increasing amount of responsibility.

We have not had the opportunity to do an exact scientific study—take their protein levels and so forth. This, in a simple statement, is too expensive in a very practical world to accomplish with a short-term group of people.

Mr. CARTER. I very much agree with that. Well, I hear from people who supplement their breakfasts and lunches which are given in these areas, and they state that children do improve in their nutritional level and it is extremely helpful.

I have another question. Do you think our migrant workers should be given food stamps in addition to their regular pay?

Dr. DOUGHERTY. The only area that we have a substantive guarantee that there is a method of feeding is in the contract with the Puerto Rican workers. Here, a cooperative or large group of farmers have gathered together to provide for service of wage negotiations, and other benefits, of course, with the Commonwealth.

In that area there are negotiations concerning food, type of diet, and other things of this sort. I am not a specialist in that area of contract negotiations, but the farmers have an obligation or the camp has an obligation to provide an adequate amount satisfactory to the demands of the people.

Mr. CARTER. What about protection for the family? What is the situation?

Dr. DOUGHERTY. The family has no such protection in terms of their negotiation background. This is why I feel strongly about the right to negotiate and bargain for wages. Nevertheless, in the camps most of the individuals are on their own. The families are on their own. They may have a relationship to the organization to assist them in purchasing and transportation, but it does not have a responsibility to feed them, nor does the farmer.

Mr. CARTER. The families supply themselves?

Dr. DOUGHERTY. Yes, sir; with what they have available.

Mr. CARTER. Do you recommend use of food stamps?

Dr. DOUGHERTY. I have looked and not delved deeply into the administrative mechanism of the food stamp program. I did look at surplus commodities, and the regulations in that area seem to be lacking. I feel if one should look at the problem, one should say where there are emergency needs for food, where the migrants have no money for purchase, immediate responsive mechanisms should be invoked.

Mr. CARTER. I certainly agree, and that goes for the use of surplus commodities, too.

Now on the issue of strikes, you feel they should have a right of collective bargaining, and I feel the majority of American people would agree that is quite true, but in that case you also mention the use of food stamps there and surplus commodities.

Dr. DOUGHERTY. The strike which I referred to was a strike of a processing group of workers of the Campbell Soup industry rather than the people supplying the raw materials to the processor. When the individuals who process the tomatoes into soup go on strike, there is really no market for the tomatoes growing in the field, and the men who are imported to pick them had no work and no wages, so this is where they came into difficulty.

Mr. CARTER. Take such cases, that is a result of a secondary fact?

Dr. DOUGHERTY. Yes, sir. They should have had immediate help, and it was obtained with great difficulty.

Mr. CARTER. They are subject to a strike by another group of people and are thrown out of work, and in such cases you would use the food stamps. I think, of course, we can all agree on that. But what if the migrant worker himself should strike; what do you think about that?

Dr. DOUGHERTY. This, I think, is a different type of issue.

Mr. CARTER. It is a different type of issue?

Dr. DOUGHERTY. Yes.

Mr. CARTER. What do you think about it?

Dr. DOUGHERTY. I think that the migrant worker, once he understands the concept of organization and the concept of collective bargaining, and he decides to go on strike, takes, in a sense, a very deliberate action, and he takes it in consideration of all of the difficulties which are going to come to him.

So therefore under those circumstances I think another type of arrangement should be generated if he is going to get into starvation.

Mr. CARTER. Well, you have not completely answered my question. Of course, in one sense, you would think if the Government gave food stamps and surplus commodities to the migrants, we might be supporting a strike, and, of course, it would be a difficult position for the Government but still we would think those children must be fed?

Dr. DOUGHERTY. Yes, indeed.

Mr. CARTER. Nothing further.

Mr. JARMAN. Mr. Preyer.

Mr. PREYER. No questions.

Mr. JARMAN. Mr. Hastings.

Mr. HASTINGS. Thank you, Mr. Chairman. Briefly, Doctor, in the long-range view of the problems, the particular problems of the migrant workers, aren't we going to be in a rather fortunate position considering the medicaid benefits; aren't we going to have to be realistic and include them within the scope of medicaid legislation, both federally and State, and going from there, possibility of reform of overall welfare system; aren't we going to decide these people are going to have to receive the benefit, for the families, incorporate it into the present bill; aren't we going to have them get all of the rights and benefits of all people within our country; isn't that really the long-range answer rather than always treating the migratory worker as a special problem?

Dr. DOUGHERTY. In terms of a long-range answer, yes; I think there is no doubt but what a mechanism for inclusion of these people into a medicaid or some type of other sponsored activity could evolve.

For example, to place it bluntly, I could not, as an individual, see the sense of the original Migrant Labor Act, because it was not striking at the root cause of the problem. The root cause of the problem was remote from the user, so therefore what you are contemplating now plus the thrust that can be brought to bear, such as the facility, the attitude, the concept of service in the supply area rather than in the demand area—hopefully at that point in time medicaid may be developed to the point where service to all of the people may be carried out effectively.

In the long run, I think we have to consider the person who comes from Florida to have eligibility for benefits there and at the same time he has eligibility for benefits in New Jersey or Minnesota or anywhere else.

Mr. HASTINGS. How about New York?

Dr. DOUGHERTY. New York, Washington, or Oregon, and the same would be true of people in Puerto Rico; there are different standards in each of the States. I think we have to level them out if we possibly can. I think that in building that mechanism, we have the issue of time.

Mr. HASTINGS. Coming from New York, I was a member of the State legislature, in study after study of the migrant labor problem over many, many years, and we studied it to death, and frankly we never, as you pointed out, reached the real problem; that is, that either migrant laborers are necessary to the agricultural economy, and we must judge they are, and if they are, we have to treat them not as second-rate citizens, and they have been fourth- and fifth-class citizens, is my understanding up to this point, and in New York there are the benefits of unemployment and the whole long list of benefits that are available to all workers, but I would certainly believe we should reach a system of nation standards and relate them to migrant workers. That should be our consideration. I see the problem, we refuse them and we never seem to have really gotten to the bottom of the problems they have.

Dr. DOUGHERTY. Mr. Hastings, I believe that the original legislation provides one of the greatest stimuli to the beginning solution of the kinds of problems we have faced. I think that continuing specific legislation on behalf of the migrant will focus attention to his plight so ultimately you can solve a great many problems and then, having solved them, incorporate the migrant into, if you wish to say, first-class citizenship.

Mr. HASTINGS. It seems to me there is a lack of financial urge to be able to sustain themselves.

Dr. DOUGHERTY. That is most important both to the migrant and also to the State and locality that attempts to make a correction.

Mr. HASTINGS. Thank you.

Mr. ROGERS. Mr. Chairman, may I bring up one more point that I want particular attention on. One of the reasons we put in this legislation the words "to provide a continuity in health service," which is a change in the language, is that we want to focus some attention on this which you just mentioned, and in going into some areas, they

get health care in one area but when he moves he does not get it right at a critical time when he may need it.

The idea of saying "a continuity of service" is to imply and set forth specifically that this problem needs to be attacked and should be under the provisions of the bill as far as health service goes. Thank you.

Mr. JARMAN. Dr. Dougherty, roughly, how much Federal money yearly is coming to New Jersey in the program and how much is the State itself putting into migrant aid?

Dr. DOUGHERTY. If I might ask my people, I think a little better than $200,000 and our estimate is, in direct State appropriation, that is in the order of $165,000, and in the order of local contributions in terms of voluntary agencies' time, local government time, we just about match the $200,000 in Federal money; so the gross value is probably more than a half million dollars spent in behalf of health services in one way or another, and this implies some deficits both in terms of hospital care and in terms of lack of payment of some outstanding bills because of the fact that we cannot adjudicate a claim of a migrant.

Mr. JARMAN. You feel that you can use more money on this program. Would it be matched at the State level?

Dr. DOUGHERTY. I think, to answer you directly, that more money could be used in terms of transportation, stimulus to hospitals, et cetera. Whether I can assure you it will be matched at State level by State appropriations at this point in time I cannot give you a fair answer on that.

I think that local funding will develop and there is a mechanism by which, through local activities, State moneys will be put into the program.

On the other hand, if I may be direct, our basic problems are in sanitation, in the fundamental services such as maternal and child care, dental health, and so on, using State-aid moneys and local communities at a great rate, and the point of view is, these are local needs and local funds, and again we have a fine distinction between a local person and a migrant. It is regretful.

Mr. JARMAN. Dr. Brumback, would you comment on Florida, the amount of money you are receiving and the amount the State supplies?

Dr. BRUMBACK. I don't have the figures for Florida, but Palm Beach County, which has roughly half of the total migrant population at the peak of the season, there is currently $220,000 in Federal money, and to match this there is $280,000 of local money; so, in other words, the proportion is greater of the local matching money.

Mr. JARMAN. That is for Palm Beach?

Dr. BRUMBACK. That is for Palm Beach County.

Mr. JARMAN. If there are no further questions, the Chair expresses appreciation for your being with us and for your contribution.

This concludes our hearings, and the subcommittee stands adjourned.

(The following letters were received for the record.)

THE ASSOCIATION OF
STATE AND TERRITORIAL HEALTH OFFICERS,
Washington, D.C., October 2, 1969.

Hon. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce,
Rayburn House Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: The Association of State and Territorial Health Officers is in full support of H.R. 13432 that would improve and extend the program of health services for domestic agricultural migrant workers and their families. We urge its enactment.

As you know, the present funding of the program restricts its benefits to only one-third of the million migrant agricultural workers and their families. Thus, if comprehensive health services are to be provided those presently participating in the program and those not now being reached, we should as a minimum triple the existing authorization for appropriations.

The manpower pool of seasonal and migratory agricultural workers and their families have health needs that are markedly greater than those of the general population. They are afflicted with high infant mortality rates, high accident rates, and high mortality rates due to tuberculosis and other infectious diseases. In the absence of medical services, they endanger not only their own health but that of the general population.

I would appreciate having this endorsement of H.R. 13432 made a part of the printed record of hearings.

Sincerely yours,

J. E. PEAVY, M.D., *President.*

SHADE TOBACCO GROWERS
AGRICULTURAL ASSOCIATION, INC.,
Windsor, Conn., October 3, 1969.

Hon. PAUL G. ROGERS,
U.S. House of Representatives,
House Office Building, Washington, D.C.

MY DEAR MR. ROGERS: Our organization, whose membership as a group, comprises one of the nation's largest employers of agricultural labor, strongly supports the principles behind the Migrant Health Act. Because since 1953, entirely at its own expense, our Association has operated the only state licensed hospital for agricultural workers in this country, we know better than most the difficulties which presently confront employers of farm labor as they seek to provide adequate medical and health care facilities for their workers. The growing crises which confronts our nation with respect to adequate hospital facilities in general is greatly compounded with respect to the maintenance and operation of such facilities for migrants and other seasonal agricultural workers, who lack any community roots in the areas where they are employed. Federal aid is more necessary today than ever before for improved migrant health facilities and the amount, in our opinion, needs to be increased substantially. For this reason, we note with approval that your bill, H.R. 13432, would increase the amount of federal funds authorized for assistance to health services for migrant and other agricultural workers from the present inadequate appropriations of $8 million annually to $30 million in fiscal year 1971 and would provide for subsequent annual increases of $15 million to a new total authorization of $60 million for the fiscal year ending June 30, 1973. In view of the great need for such services which is unmet today, we regard the amounts you propose as modest and necessary. We also believe that the other changes in existing law which your bill proposes are constructive, and we therefore give H.R. 13432 our complete support.

We would, however, like to suggest one additional amendment which would, in our view, greatly extend the usefulness of this legislation and permit it to meet a major need. This would be the addition of the word "construction" to the various kinds of assistance to migrant health which the act authorizes. There is a great need for many new facilities, such as clinics and even special agricultural workers hospitals, to be constructed and the law does not permit help to this end. Thus, while the present law makes important services to migrants available, they often cannot be instituted in the areas where they are most needed because of the lack of facilities to house them.

We realize that, because the total funds for migrant health assistance are so limited, it may be necessary to limit the proportion of funds which could be used for construction purposes at the present time. We believe, however, that the Public Health Service officials who administer these funds are probably in the most effective position to determine the priority needs for migrant health assistance and we therefore recommend that, rather than a limit on the total amount which could be used for construction, any limitation, if Congress feels one is necessary, should be in the nature of requiring matching funds. These could be either equal, or in some specified proportion, to be provided by the recipients of such aid for construction of migrant health facilities. Any such limitation should apply only to funds used for construction.

The accompanying statement outlines in detail our experience in trying to maintain adequate hospital and medical services for some 22,000 migrants and

seasonal agricultural workers employed by our members annually. While we now maintain what is unquestionably the highest quality medical care available to agricultural workers anywhere in the nation, we are greatly concerned about the future. Economic conditions in the shade tobacco industry and the soaring costs of hospital and other health facilities now make it impossible for us to continue these services without federal aid at the level we believe our workers are entitled to have available. Since even the standards our Association has maintained, which had led the nation for many years, now are inadequate, the need for continued and expanded federal aid under the Migrant Health Act by other employers and their workers is all the more evident. This program is essential on grounds of humanity. Migratory and agricultural workers, like others, are entitled to decent hospital and medical care when they require it and such services now are beyond the capability of most farm employers and farm communities to provide without substantial federal help. But, in addition to these human considerations, there are also sound reasons from a practical standpoint for continuing and expanding the migrant health programs as you propose.

Agriculture, which depends upon the availability of an adequate labor force, remains one of the mainstays of our national economy in spite of the depression which farm employers in general have experienced in recent years. Without adequate health care for its workers, agriculture would find itself unable to obtain the labor force needed to harvest our nation's crops, yet at the present time this industry's economic condition and outlook is such that it simply cannot meet hospitalization and other health care costs out of its substandard earnings, which for many years have been far below parity.

Perhaps the most compelling reason of all why the help proposed in your bill is essential is that the national public interest requires it on grounds of public health. Disease knows no geographical, occupational or social boundaries. If Congress should fail to provide adequate health care for migratory and other seasonal agricultural workers, it would fail to protect our entire population as well.

We commend you and Chairman Harley Staggers of the House Interstate Commerce Committee for the leadership you have both shown in the area of migrant health legislation in the past and we urge the members of the committee to support your bill without reduction in the amount of funds it would authorize or other amendments, except for the construction authorization which we respectfully request be added.

Very truly yours,

MARK R. KRAVITZ, *Executive Director.*

THE SHADE TOBACCO GROWERS AGRICULTURAL ASSOCIATION, INC.

THE AGRICULTURAL WORKERS HOSPITAL, WINDSOR, CONN.

1. History and sponsorship

The Agricultural Workers Hospital of The Shade Tobacco Growers Agricultural Association, Inc., established in 1953, is the only state-licensed hospital for migratory farm workers in the United States. It has been financed to date entirely by members of the Association, a non-profit cooperative organization comprised of the growers of shade tobacco in the Connecticut River Valley, involving areas in both Connecticut and Massachusetts. The Association, established in 1942, serves exclusively in the areas of recruiting, contracting, transporting, feeding, housing, insuring and supervising of the farm workers employed by its grower members. Between 6,000 and 7,000 acres of shade tobacco, yielding about 10 million pounds, are planted each year. The crop, used exclusively for the outside wrappers of quality cigars, is grown entirely under cloth—and is dependent entirely upon hand labor since any bruising or other marring of the wrapper leaf destroys its commercial value. The shade tobacco industry is one of Connecticut's major agricultural enterprises with a labor force of some 12,000 seasonal day-haul workers recruited in the area and about 10,000 "migrants", or out-of-state seasonal workers. About 2,000 workers are employed by the Association and its grower members full time the year round. The Association's annual payroll totals more than $27,000,000.

The Association has been a pioneer in better labor standards for farm workers and has won both national and international acclaim as a progressive and enlightened agricultural organization. Today, its headquarters and model farm labor camp, occupying 19 acres in Windsor, Connecticut, are pointed to throughout the world as outstanding institutions in agriculture and are visited each

year by agricultural leaders from all over the nation who are interested in inspecting its outstanding housing, recreational and cafeteria facilities, representing an investment of more than $3,000,000.

The Association has had a hand in drafting and securing the enactment of every regulation or law in the State of Connecticut dealing with the employment of agricultural labor. Regulations and laws which it sponsored to protect farm workers from substandard housing, transportation, sanitation and working conditions helped to give the State of Connecticut its present reputation for the best agricultural labor standards in the nation.

These and other actions by the Association have earned for it a reputation as one of the most enlightened and progressive agricultural employer groups in the entire country.

In 1953, the Association decided to create a facility which would give its migrant agricultural workers the kind of medical care needed and due them. It was the Association's theory that a centralized hospital which could be used by all of the growers would better meet the medical needs of the workers.

Accordingly, the Association established a 32-bed hospital at the Bradley Farm Labor Supply Center, located on North Street in the town of Windsor Locks, Connecticut, a facility which was formerly the Engineering Section of Bradley Airfield during World War II. This site was selected because in 1953 the Bradley Farm Labor Supply Center was the principal labor supply center for the Association and at that time was the best facility of the Association.

A building, formerly the Officer's Lounge of the Bradley Airfield Engineering Section, was chosen to house the Agricultural Workers Hospital and was renovated at a cost to the Association of $70,000. Health Commissioner Dr. Stanley Osborne, of the Department of Health of the State of Connecticut, and the Association worked out an arrangement whereby the Agricultural Workers Hospital was licensed by the State as a general hospital. Later, it was decided to license it as a special hospital devoted to the needs of migrant agricultural labor.

II. Staff

The staff of physicians from the inception of the hospital through 1967 was as follows: Dr. Ettorine Carniglia, chairman; Dr. Warren Silliman, secretary; Dr. John Kennedy; Dr. Sidney Cramer; Dr. William Pomeroy; Dr. William Bard.

All but one of the original six who started with the Association in 1953 are still with the hospital. Presently five doctors constitute the medical staff and meetings are held monthly with discussions of the problems of the operation of the hospital and bettering the services to the migrant workers regularly on the agenda.

The hospital's nursing requirements are principally performed by registered nurses. During the height of the crop season, when many agricultural workers are in the area, the staff of nurses at the hospital is increased to cope with the services required by the patients as well as to meet the specified requirements of the State. The Manager of the hospital presently is Marco Malo, a registered nurse. The orderly staff of the hospital consists of three persons.

In addition to the staff nurses of the hospital, the Association provides nursing services at some 30 camps housing approximately 3,000 boys and girls 14 to 16 years old, who are recruited out of the state as part of its outstanding summer Youth Program. Camps are visited on a regular basis at least once a week to provide minor nursing services and administer medical supplies. These nurses are available on call at all times to take care of emergency cases. When hospital care is needed by participants in the Youth Program, however, city facilities are used rather than the Agricultural Workers Hospital, which administers only to adult workers.

III. Need for the hospital

The migratory labor force employed by the Association in Connecticut and Massachusetts represents approximately 90% of all migrant farm workers in this area. The farm labor operations of the Association are carried out in an area where all other hospitals are privately endowed and are unable to accept many of the cases among seasonal agricultural workers who need hospital care, i.e., mumps, chicken pox, measles and respiratory infections. The worker is away from home and minor, as well as major diseases must be treated in an institution to keep them from spreading throughout the camp area. If the worker were at home, he would be treated by a doctor and then continue his treatment and recovery at home, but since he is living in a labor camp provided by the Association or a grower, special medical attention and hospitalization is required.

A review of all the cases admitted to the hospital in the fiscal year December 1, 1967 through November 30, 1968 is representative of this problem. The attached Appendix I gives a summary of the cases taken care of by the Agricultural Workers Hospital in this period. A glance over the list of diseases and injuries treated by the hospital in the course of one fiscal year makes it evident that many could not be treated in privately endowed hospitals with the overcrowding and dire shortage of space which exists in such hospitals in the area at the present time.

Thus, the health and welfare of migrant agricultural workers in the Connecticut River Valley depends almost exclusively on the operation of the Agricultural Workers Hospital. It would be impossible for the Association to provide the migrant worker the medical care which is necessary and due him without this facility.

The Association recognizes that it would be almost impossible to operate the shade tobacco business in the Connecticut Valley without this facility.

IV. Need for Federal assistance

Despite the obvious need for this facility, The Shade Tobacco Growers Agricultural Association, Inc. is finding the continued operation of the hospital almost impossible at the present time. Starting in 1958, the Association completely rebuilt its Windsor Farm Labor Supply Center and operations are now centered at this point.

The present Agricultural Workers Hospital is crowded, antiquated and outdated. The existing wooden two-story building, with narrow corridors, although sprinklered, is of questionable security for the patients. The Association spent approximately $30,000 to repair and refurbish the building in the last two years, although it merely rents the facility and may have to relinquish it at any time to military demand. Because the need for a new hospital building is obvious, the Association has purchased land next to its modern Windsor Farm Labor Supply Center and earmarked it for this purchase. Plans for a new facility were drawn by an architect and several thousand dollars spent to bring water to this site. It wanted to build a new modern hospital facility containing 30 beds but it is impossible for the Association to finance this undertaking at the present time.

Within the present year a crisis with regard to the hospital has developed. The present building no longer meets the state's regulations, and with stricter regulations effective July 1st, immediate action is required if the hospital is to continue to operate next year.

For this reason, the Association, which heretofore has financed all of its improvements and services on behalf of its migrant agricultural workers, is applying for federal help for the first time in its history. Shade tobacco, it perhaps should be noted in passing, does not receive the subsidies given to other forms of tobacco and the shade growers, accordingly, have received no federal assistance in any form up to this time.

V. Amount of Federal Migrant Health Act funds sought and their purpose

To meet the immediate needs of providing improvements which will enable the Agricultural Workers Hospital to continue its essential services to the migrant workers of the Connecticut River Valley, the Association itself has made $75,000 available. It also proposes to renovate an existing housing unit at its Windsor Farm Labor Supply Center to provide a modern facility and more space for its hospital. This building, with an appraised worth of $100,000, is of cinder block, one-story construction and contains 5,700 square feet of floor space. In consultation with Connecticut State Health Department officials, the Association has worked out plans for renovating and adapting this building at a cost of $130,000.

Since such an amount exceeds the funds available to the Association, it is seeking help in the form of federal assistance under the Migrant Health Act in the total minimum amount of $50,000, of which $30,000 would be for renovation and $20,000 would be in the form of aid to improve services and other assistance. The latter would allow the Association to apply its own funds which it otherwise would have to spend for improving these services toward the cost of renovating the building to be used to house the hospital.

In seeking these funds, the Association has one primary objective—to improve and deliver more quality care to the migrant agricultural workers employed by members of the Association. It would accomplish this in three ways:

1. It would provide, through renovation of an existing facility, a modern hospital building with 30 beds and additional needed space and facilities, which would conform in all ways with the reguiations of the State of Connecticut for hospital use.

2. It would increase the quality and services afforded to migrant workers through its out-patient department, which now is inadequate to the needs.

3. It would provide more comprehensive and higher quality care for in-patients.

VI. Special needs of outpatient services

The present facilities of the hospital clearly are inadequate to meet the needs of the large number of workers requiring out-patient care. The waiting room and examining rooms are inadequate and added space must be provided for them. Moreover, at present, both in-patient and out-patients must use the same facilities and the danger of cross-contamination is greatly increased.

Plans for the renovated building call for the establishment of minimal X-ray facilities for out-patient care, requiring the installation of lead walls and ceilings in a special room for this purpose. Such facilities are badly needed since it is now necessary to send patients requiring X-ray examination to the City of Hartford, usually causing at least a full day's delay before treatment can begin. This facility would eliminate the present cost of transportation to Hartford, release an attending staff member for duty at the hospital, and reduce additional radiology expenses.

Besides lack of adequate space and necessary facilities, the hospital presently lacks an adequate staff to provide the improved services required by its out-patient department. The Association proposes, through providing better facilities, to increase the services provided by its present staff as well as to expand its services by additional staff adequate to handle the work load. Additional clerical help is urgently needed to process the records of out-patients, releasing a nurse from this duty, thereby reducing the unavoidable delays which migrant workers needing medical attention now face. These delays discourage them from returning to the hospital for future care and they thus are more likely to fail to seek medical attention for minor, but contagious, ailments because of the inability of the present staff to treat them promptly. The Association, while recognizing that additional staff is necessary, finds itself unable to finance its cost at the present time. Expenditures for direct operating salaries of the hospital, exclusive of the physicians' fees, totalled $68,000 last year, an increase of $9,000 over the previous year's wage costs.

VII. *Special needs of inpatient services*

Since the same nursing staff of the hospital handles both in-patient and out-patient needs, the remarks above concerning the inadequacy of the present staff with respect to out-patient care apply equally to their ability to provide top quality care to in-patients. If additional staff and better facilities are made available, the quality of in-patient care automatically will increase. The biggest need of the in-patients at the present time, however, is for a more adequate hospital building and facilities. Not only does the present wood building fail to meet even the lower State standard for nursing homes, but it is crowded and does not provide all of the facilities required for the quality of medical care which the Association wishes to provide its workers.

Assistance from the federal government also is needed to help underwrite the increasing costs of medical care for in-patients. The hospital is presently financed in part by receipts from hospitalization insurance which the Association provides its adult migrant workers. This provides $15.00 a day per patient toward the cost of such services and the grower members of the Association make up the difference in the cost of running the Agricultural Workers Hospital through assessments. Federal assistance under the Migrant Health Act to help underwrite the rising costs of running the hospital is essential at the present time in view of the need for the Association to devote all its available funds to undertaking the extensive renovation of its hospital facilities.

VIII. Budget for requested Federal aid

The minimum total of $50,000 in funds requested for the Association under the Migrant Health Act would be used as follows:

For renovation of existing building to provide improved hospital facilities so that they will meet state regulations, $30,000.

For additional staff to improve in-patient and out-patient care and help in underwriting costs of operating the hospital, $20,000.

AMERICAN HOSPITAL ASSOCIATION,
Washington, D.C., October 15, 1969.

HON. JOHN JARMAN,
Chairman, Subcommittee on Health, Interstate and Foreign Commerce Committee, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to submit to you on behalf of the American Hospital Association this letter in support of Congressman Paul Rogers' bill H.R. 13432 to extend and expand the program of project gratns to public or other nonprofit agencies, institutions and organizations for improving health services for migratory agricultural workers and their families.

Enactment of the Migrant Health Act by Congress in 1962, recognized the almost total lack of health care for migrant farm workers and the difficult and unique problems involved in seeking to remedy the health neglect of these workers and their families. Project applications have from the start of the program far exceeded the available funds, and we understand only about ⅛ of the nation's one million migrant agricultural workers are receiving health services under the program. We feel it has, however, functioned effectively in reaching a maximum number of migratory farm families with the available resources.

The American Hospital Association supported the original legislation and the 1965 and 1968 extensions of the program. We fully support H.R. 13432.

The bill would increase the annual authorization for the program from the present $15 million for the fiscal year 1970 to $30 million for the fiscal year 1971, to $45 million for the fiscal year 1972, and to $60 million for the fiscal year 1973. These increases are justified, in our view, by the size of the problem and by the fact that many communities and organizations are ready to initiate new health projects for migratory agricultural workers or to expand existing projects as soon as funds are available under the program.

We are pleased the bill would extend the program to "other seasonal agricultural workers." Seasonal and migrant farm workers often work and live side by side in the same community. They face much the same problems with regard to obtaining needed health services and care. They and their families endure the same conditions of poverty and poor environment and are victims of many of the same nutritionally based diseases. On the basis of need and from the standpoint of fairness we favor including seasonal agricultural workers and their families as beneficiaries under the program.

We also support the amendment to spell out as one of the aims of the program the providing of "a continuity in health care." At the time of your Committee's consideration of the Community Health Services Extension Amendments of 1965, representatives of the Department of Health, Education and Welfare testified that the language of that bill would be interpreted to permit payment for in-hospital care as part of a migrant health project. Funds to pay for hospitalization under the program did not become available until 1967, however, and we are advised that at the present time only half of the migrant health projects provide in-hospital care along with other health services. Approval of this amendment will, we trust, help to insure needed in-hospital care, in all appropriate cases, included in the health services provided through migrant health projects.

In connection with payment for in-hospital services under the migrant health program, we wish to call to your Committee's attention the following problem. Hospitals in migratory labor areas are called on from to time to time to provide both emergency and in-hospital care for migrant workers who suffer accidental injuries or become ill while traveling from one migrant labor camp or point of migrant labor concentration to another. These hospitals feel they should not be called on to absorb the cost of providing such care. We agree and we request that your Committee, by language in your report on H.R. 13432 or otherwise, call on the Public Health Service officials administering the program to take steps to see that the costs of hospital services in this type of case are paid through local migrant health projects.

The final provision of H.R. 13432 would specifically authorize grants for training persons in the allied health professions for work in the migrant health program. This is desirable both from the standpoint of improving the program and bringing about more efficient use of health manpower.

We appreciate the opportunity of presenting these comments on and expressing our support of H.R. 13432, and we ask this letter be made a part of the hearings on the bill.

Sincerely,

KENNETH WILLIAMSON,
Deputy Director.

(Whereupon, at 12:10 p.m. the subcommittee adjourned.)